

**CLAIM FORM - [For use on Brit Insurance Limited underwritten policies]**

To help us provide you with a fast and efficient service, we kindly ask you to note the following:

- A fully completed form will speed up the assessment and payment of your claim;
- Please complete the front page of this form and ask your treating doctor to complete the back page;
- All relevant original invoices must be attached. Unfortunately, photocopies, receipts and credit card slips cannot be accepted;
- If you are submitting invoices from Germany or the USA, or if your invoices contain details of diagnoses as well as the nature of your treatment, there is no need to complete the reverse side of this form, simply attach the original invoices;
- A separate claim form is required for every patient and each medical condition;
- We recommend that you keep copies of all documents submitted, should you require them at a later date;
- Finally we kindly ask that you complete this form in **BLOCK CAPITALS**, and post to the address below, within 3 months of the treatment date.

**IMPORTANT:** IF THIS CLAIM IS A CONTINUATION OF A PREVIOUS CLAIM WITH MORGAN PRICE, OR FOR A CONDITION WHICH YOU HAVE CLAIMED FOR BEFORE, PLEASE TICK HERE [ ] AND PROVIDE DETAILS ON A COVERING SHEET.

**1. Policyholders Details**

Policy Number (Must be completed)	<input type="text"/>	Title	<input type="text"/>
Surname	<input type="text"/>	First Name(s)	<input type="text"/>
Correspondence address	<input type="text"/>		
		Postcode	<input type="text"/>
Phone No. (Daytime)	<input type="text"/>	(Evening)	<input type="text"/>
Mobile Phone No.	<input type="text"/>	Fax	<input type="text"/>
Email	<input type="text"/>		

**2. Patients Details**

Title	<input type="text"/>	Surname	<input type="text"/>	First name(s)	<input type="text"/>
Date of Birth (dd/mm/yy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
Is this claim related to an accident?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

**3. Payment Details**

**Option 1 Payment to Policyholder/Insured**

Payment to be made in:	Invoice currency	<input type="checkbox"/>	Other currency (Please specify)	<input type="text"/>
Preferred payment method	Bank Transfer (please complete bank details below)	<input type="checkbox"/>		
Name of bank account	<input type="text"/>			
Account no. / IBAN	<input type="text"/>	Sort/branch code	<input type="text"/>	
Swift Code	<input type="text"/>	Bank Name	<input type="text"/>	
Bank Address	<input type="text"/>			

**Option 2 Payment to Provider of Medical Services (e.g. Hospital, Specialist, MRI)**

Please tick if Direct Billing has been previously agreed with Cega Air Ambulance Limited

**4. Patient Signature and Release**

I certify that to the best of my knowledge, this claim form does not contain any false, misleading or incomplete information. I understand that in the event that this claim is found to be fraudulent in whole or in part, the policy will be invalidated and I will be liable for prosecution. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical establishment to provide any health details or medical records that may be requested by Morgan Price International Healthcare Ltd, Cega Air Ambulance Limited or their appointed representatives.

**If a minor was treated, a parent or guardian should sign this section.**

Patient signature	<input type="text"/>	Date (dd/mm/yy)	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
-------------------	----------------------	-----------------	----------------------	---	----------------------	---	----------------------

TO BE COMPLETED BY THE TREATING DOCTOR IN **BLOCK CAPITALS**.

**5. Medical Provider Information**

Name of doctor/specialist			
Qualifications/credentials			
Name of hospital/clinic			
Address			
Post Code		Country	
Phone No.		Fax No.	
Email			

**6. Medical Information**

Has Treatment Authorisation been obtained ?  Yes (please attach details)  No

Indicate type of treatment received ?  Elective  Emergency

Indicate type of condition  Acute  Chronic  Acute episode of a chronic condition

**Please provide full details of the medical condition requiring treatment, including ICD code/DSM-IV**


On what date did the patient first present these symptoms to you ? Date (dd/mm/yy)  /  /

Prior to consulting you, when did the patient first notice signs or symptoms of this medical condition ? Date (dd/mm/yy)  /  /

Are you aware of any treatment given for this or any related illness in the past ?  Yes  No

If Yes, please give details :


**Applicable to physiotherapy/psychotherapy claims only. Please provide full referral details.**

Name of referring physician			
Telephone number			
Date of referral (dd/mm/yy)			

**Applicable to dental treatment only**

Was the patient suffering from dental pain at the time he/she visited you for treatment ?  Yes  No

Doctors Signature			<b>STAMP</b>
Date (dd/mm/yy)	<input type="text"/> / <input type="text"/> / <input type="text"/>		

The confidentiality of patient and member information is of paramount concern to us. Morgan Price International Healthcare Ltd and Cega Air Ambulance Limited fully comply with the European Data Protection Legislation and International Medical Confidentiality Guidelines. You have a right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.